HHS/MFP COMMITTEE #1
October 25, 2010

MEMORANDUM

October 22, 2010

TO: Health and Human Services and Management and Fiscal Policy Committees

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Discussion: Impacts of Health Care Reform on County and Bi-County Agency Employee Benefits**

Those expected for this session

Joe Adler, Director, MCG Office of Human Resources
Wes Girling, Benefits Division Manager, MCG Office of Human Resources
Kathleen McAuliffe, Senior Vice President, AON
Belinda Fulco, Benefits Manager, MCG Office of Human Resources
Marshall Spatz, Director, MCPS Department of Management, Budget, and Planning
Susanne DeGraba, MCPS Chief Financial Officer
Karen Bass, Montgomery College Benefits Office
Yvonne D. McKinney, Director, WSSC Human Resource Office
Sheila Cohen, WSSC Division of Finance
Jan Lahr-Prock, M-NCPPC Health and Benefits Manager

During its June briefing with the County Health Officer on the implementation of Health Care Reform, the Management and Fiscal Policy and Health and Human Services Committees requested a joint session to discuss with the county and bi-county agencies their assessment to date of the impacts of health care reform on employee health care benefits and any estimate of costs associates with required changes.

Representatives from the agencies will be present to discuss this issue with the joint Committee. Attached to this memo is information from Montgomery County Government

(©1-4); Montgomery College (©5); Montgomery County Public Schools (©6-7); and the Washington Suburban Sanitary Commission (©8-13). The Maryland-National Capital Park and Planning Commission will be providing information to the joint Committee at the session. Council staff has also spoken with the Housing Opportunities Commission regarding this issue. HOC has a participatory agreement with the Montgomery County Government for health benefits and so the impacts noted by County Government will also impact HOC. HOC said there was minimal immediate impact from the recent change to allow dependents up to age 26 to remain on their parent's plan as most employees who asked to add a dependent back already paid for a family plan.

In addition to the information provided by County Government (©1-4), the Office of Human Resources has provided the following information that says the County Government plans are considered grandfathered plans. This issue of grandfathered plans is also raised in the information from MCPS (©6-7) which provides their assessment that the MCPS plans are not grandfathered.

> *Montgomery County Government believes the Choice and Select Plans (the Plan) are grandfathered health plans under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.*

Attached at ©14-18 is a summary from the Henry J. Kaiser Family Foundation of the main provisions of Health Care Reform. The following are selected provisions that staff expects would apply to agency health plans.

Calendar Year 2010 (County FY11)

- Coverage cannot be denied to children under the age of 19 because of a pre-existing condition.
- Insurance companies are prohibited from rescinding coverage because of an error on a customer's application.
- Insurance companies are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.
- Annual dollar limits on the amount of insurance coverage a patient may receive will be restricted.
- Consumers are provided with a way to appeal coverage determination or claims.
- Preventive care such as mammograms and colonoscopies but be provided without charging a deductible, co-pay, or co-insurance.
- Young adults under the age of 26 may remain on their parent's plan unless the person is offered insurance at work.
- The federal government is offering assistance in covering the cost of providing health insurance to early retirees (between the ages of 55 and 65).

Calendar Year 2011 (County FY11 and FY12)

- Seniors on Medicare who reach the coverage gap for prescription drugs will receive a 50% discount when buying covered brand-name drugs. Additional discounts will be received for the next 10 years until the coverage gap is closed.
- Medicare will provide free preventive services such as annual wellness visits.
- High-risk Medicare beneficiaries will receive services through the Community Care Transitions Program to prevent hospital readmissions.
- Exclude the cost for over-the-counter drugs not prescribed by a doctor from being reimbursed through health reimbursement account or flexible spending account.

Calendar Year 2012

- CLASS, a new voluntary option for long-term care insurance will be in place to provide benefits to adults who become disabled.

Calendar Year 2013

- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by a cost of living adjustment.
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Calendar Year 2014

- Insurance companies may not refuse coverage because of an individual's pre-existing condition.
- Health plans must not have annual limits in insurance coverage.
- Limit waiting periods for coverage to 90 days.
- Insurance companies may not drop or limit coverage because an individual chooses to participate in a clinical trial that treats cancer or other life-threatening diseases.
- Workers meeting certain requirements who cannot afford the coverage provided by their employer may take what ever funds their employer would have contributed and use then to purchase more affordable health care.
- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (through 2019).
- Permit employers to offer employees rewards for participating in wellness programs.

Calendar Year 2018

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage.

Health Care Reform

Montgomery County Government

Calendar Year 2010 (County FY11)	Impact
• Coverage cannot be denied to children under the age of 19 because of a pre-existing condition.	Applies – no cost impact since already included in the County plans.
• Insurance companies are prohibited from rescinding coverage because of an error on a customer's application.	Applies to individual plans the County plans do not allow rescissions.
• Insurance companies are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.	The County eliminated the $2,000,000 lifetime limit on the CareFirst POS out of area plan and the $1,000,000 lifetime limit on the CareFirst retiree indemnity plan effective January 1, 2011. Estimated CY 2011 cost is $75,000.
• Annual dollar limits on the amount of insurance coverage a patient may receive will be restricted	The County does not have annual dollar limits on any essential benefits
• Consumers are provided with a way to appeal coverage determination or claims.	The County plan has maintained grandfathered status and this does not apply to grandfathered plans. However, an appeals process is already in place and is communicated in Summary plan documents.
• Preventive care such as mammograms and colonoscopies provided without charging a deductible, co-pay, or co-insurance.	The County has maintained grandfathered status so this provision does not apply. The County currently covers many preventive care services without copay. Over time, increased preventative care is expected to reduce health care costs.
• Young adults under the age of 26 may remain on their parent's plan unless the person is offered insurance at work.	The County complied effective September 1, 2010. Approximately 350 new dependents were added to the plan. The estimated CY 2011 cost is $525,000.
• The federal government is offering assistance in covering the cost of providing health insurance to early retirees (between the ages of 55 and 65).	The County applied for this program and the application has been approved. The County is working on next steps as they are released.

(1)

Health Care Reform

Montgomery County Government

Calendar Year 2011 (County FY11 and FY12)	Impact
• Seniors on Medicare who reach the coverage gap for prescription drugs will receive a 50% discount when buying covered brand-name drugs. Additional discounts will be received for the next 10 years until the coverage gap is closed.	This applies to Medicare Part D programs. The County covers retirees under its own prescription program. The County will continue to explore options for providing prescription coverage to retirees.
• Medicare will provide free preventive services such as annual wellness visits.	No cost impact to the County. May have a long term positive effect on the health care cost for the Medicare Supplement plans.
• High-risk Medicare beneficiaries will receive services through the Community Care Transitions Program to prevent hospital readmissions.	No cost impact to the County. May have a long term positive effect on the health care cost for the Medicare Supplement plans.
• Exclude the cost for over-the-counter drugs not prescribed by a doctor from being reimbursed through health reimbursement account or flexible spending account.	May have minimal effect on FICA as employees have lower pre-tax elections. The County will analyze FSA elections for 2011,
• New Taxes on Health Care Service Providers — Prescription drug manufacturers: $2.5 billion in 2011	Taxes will most likely be passed through to the County's self insured plans in the form of higher prescription drug costs.

Calendar Year 2012	Impact
• Uniform Summary of Benefits — A new 4 page description of benefits is to be provided in addition to an SPD.	Additional communication to employees. The County will need to revise its communications format and strategy to comply
• CLASS, a new voluntary option for long-term care insurance will be in place to provide benefits to adults who become disabled.	The County already offers employees a long term care plan. It will be voluntary for employers to offer. The County would probably not offer the program since it would duplicate the current plan but with benefits and costs that are not expected to be competitive with the current offering.
• W-2 Reporting — Employers required to include on W-2 the value of health benefits provided to each employee — Further guidance is needed to determine the definition of the value of the health benefits that will be reported.	Originally slated to occur for 2011. W-2 reporting has been delayed until 2012. W-2 reporting will require administrative changes (payroll reporting etc.).

(2)

Health Care Reform

Montgomery County Government

Calendar Year 2013	Impact
• Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by a cost of living adjustment.	No impact to the County since the maximum is currently $2,500.
• Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.	Not applicable.
• Comparative Effectiveness Tax - A new annual fee of $1 per participant beginning in 2013, then $2 per participant, sunsets at end of 2018	Estimated at about $300,000 for 2013 through 2018 (based on members).
• New Taxes on Health Care Service Providers — Medical device manufacturers: 2.3% tax on sales beginning in 2013	Taxes will likely be passed through to the County's self insured plans.
• Employers required to provide employees written notice about Exchange and subsidies	Addition communication requirement

Calendar Year 2014	Impact
• Insurance companies may not refuse coverage because of an individual's pre-existing condition.	Not applicable – The County provides comprehensive coverage without pre-existing condition limitations.
• Health plans must not have annual limits in insurance coverage.	Not applicable – The County provides comprehensive coverage without limitations on essential services.
• Limit waiting periods for coverage to 90 days.	Not applicable – The County does not have a waiting period.
• Insurance companies may not drop or limit coverage because an individual chooses to participate in a clinical trial that treats cancer or other life-threatening diseases.	The County has maintained grandfathered status and this doesn't apply to grandfathered plans
• Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer would have contributed and use then to purchase more affordable health care.	Since the County provides comprehensive medical coverage at relatively low cost, this provision should have minimal, if any, impact. However, administration of this provision may be a burden.

Health Care Reform

Montgomery County Government

Calendar Year 2014	Impact
• Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (through 2019).	This applies to Medicare Part D programs. The County currently covers retirees under its own prescription program.
• Permit employers to offer employees rewards for participating in wellness programs.	This is currently permitted. The amount permitted will be increased from 20% to 30% of premium . The County currently does not offer employees rewards for participating in wellness programs.
• New Taxes on Health Care Service Providers Health insurance companies : $8.0 billion in 2014	Taxes will likely be passed through to the County's self insured and fully insured plans.
• Large employers required to auto enroll employees into health benefits	Will require some administrative changes and determination of the "default" enrollment.

Calendar Year 2018	Impact
• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage.	Barring changes to plan design, the County plans will exceed these values before 2018 based on current plan design and historical trends. The County will be subject to the 40% excise tax.

Montgomery College

October 19, 2010

Ms. Linda McMillan
Senior Legislative Analyst
Montgomery County Council
100 Maryland Avenue
Rockville, MD 20850

RE: Health Care Cost Reform

Dear Ms. McMillan:

We are pleased to know that the Council's HHS and MFP Committees are beginning to address the issues that surround the impact Health Care Reform will have on the County agencies' health care programs. While the immediate fiscal impact is not significant, the additional administrative burden that will be placed on our staff over the next few years is of great concern. As you are aware there are increased required communications and new reporting requirements. The communication efforts have already begun in preparation to educate our employees and retirees on the impact Health Care Reform will have on all of our plans.

Montgomery College anticipates a 1+% increase in costs as a result of the plan changes to become effective January 1, 2011. These changes include covering dependents to age 26 and removing the lifetime maximum from our POS plan. An additional 1+% increase will also be incurred once we lose our "grandfathered" status and are required to cover all preventive care at 100%. In an effort to address our rising health care costs and what may become a problem when the anticipated excise tax becomes effective in 2018, Montgomery College plans to conduct as full review and possible re-design of our health plans with serious consideration to implement a Consumer Driven Health Plan effective 1/1/2012. At this time we would lose our "grandfathered" status.

As a result of the changes in the flexible spending accounts in 2012 and 2013, we anticipate a slight increase in our FICA taxes as the employees' will be limited on what they can be reimbursed for and what can be sheltered. At this time we do not have a full understanding of the cost impact associated with the changes coming forth in 2014, but we will be monitoring the status on a continuing basis.

We look forward to working with you over the next few years.

Sincerely,

Lynda S. von Bargen
Deputy Chief Human Resources Officer

cc: Ms. Lawyer
Ms. Bass

Office of the Superintendent of Schools
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland

September 8, 2010

MEMORANDUM

To: Members of the Board of Education

From: Jerry D. Weast, Superintendent of Schools

Subject: Impact of the *Affordable Health Care Act of 2010* on Montgomery County Public Schools' Employee Health Plans

The purpose of this memorandum is to inform you of the impact of the *Affordable Health Care Act of 2010* on Montgomery County Public Schools' (MCPS) employee health plans.

Changes to the MCPS employee health plans, which will be effective January 1, 2011, include free preventative care, mental health parity (i.e., all mental health treatment would be subject to the same coverage as other physician visits), and elimination of the disqualification of age 26 dependents who have access to their own health coverage through an employer. Implementing the required changes on January 1, 2011, will cost approximately $1.1 million during Fiscal Year (FY) 2011. This is based on an assumption that 1,000 of the 3,000 eligible dependents will return to their parents' plans. Costs will increase if more dependents return.

Annual costs of the plan changes for FY 2012 and beyond are estimated at $2.2 million for the active employee health plans. Costs for the retiree health plans affect FY 2012 because of the July 1, 2011, date to opt in to the plan, and are estimated at approximately $400,000, due to the anticipation that retirees have far fewer dependents eligible to return to the health plans.

There was an option to delay implementation of the changes for three years. However, when the regulations for this legislation were issued, they included specifications that any change in copayment in excess of $5 or greater than an increase in the Consumer Price Index would trigger a loss of grandfather status of the plan. As you know, MCPS increased the emergency room copayment from $50 to $100. This increase was prudent to incentivize employees to seek cost-effective alternatives to emergency rooms visits for nonemergency situations. It is anticipated to save the plans $600,000 per year. As a result of this increase, MCPS cannot delay implementation of the law for three years.

The regulations did provide that employers could choose to rescind changes that were negotiated prior to the issuance of the regulations; however, renegotiating all contracts as the school year

begins would have a negative effect on employees who already are affected by the economic constraints in these challenging budget times. The County Government's announcement that it will begin covering employees' dependents up to age 26 as of September 1, 2010, also has affected morale among MCPS employees.

If you have any questions, please contact Mr. Larry A. Bowers, chief operating officer, at 301-279-3626 or Mrs. Susanne G. DeGraba, chief financial officer, Department of Financial Services, at 301-279-7265.

JDW:LAB:sgd

Copy to:
Executive Staff
Mrs. DeGraba

Washington Suburban Sanitary Commission

14501 Sweitzer Lane · Laurel, Maryland 20707-5901

October 22, 2010

The following is presented to the Montgomery County Council HHS and MFP Committees by Washington Suburban Sanitary Commission Human Resources Office regarding the impact of Health Care Reform on health insurance policies offered to our employees and retirees.

Prepared and Submitted by: Carole Silberhorn, Human Resources Manager – Benefits
Yvonne D. McKinney, Director, Human Resources Office

IMPACT OF AND COMPLIANCE WITH HEALTH CARE REFORM

Health Care Reform Law
The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, signed by President Barack Obama March 23, 2010.

WSSC's plans will be grandfathered for 2011.

Age 26 impact assumption cost for medical and dental for 2011

Medical:
Current age 25/new 26: no impact
Current age 23/new 26: 0-.5% increase
Current 19/new 26: 1-4% impact

Dental:
$15,000 in 2011

Calendar Year 2010 (FY11)
• Assess applicable effective dates for grandfathered, non-grandfathered plans and collectively bargained plans
• Apply for small business (<25 employees) tax credit for providing health coverage, *if applicable*
• Address accounting implications of elimination of tax exclusion of retiree drug subsidy in 2013, *if applicable*
• Apply for federal reinsurance program if employer provides retiree health coverage for retirees between the ages of 55 and 64 (ERRP)
• Effective for plan years beginning after September 23, 2010, plan design changes include:
o No pre-existing conditions exclusions for dependents under age 19
o No lifetime dollar limits
o Only "restricted" annual limits allowed (per HHS)
o Dependent coverage to age 26
o Preventive care coverage without cost sharing
o No rescissions except for fraud
o Cover emergency services without prior authorizations and in- or out-of-network
o Allow designation of OB/GYN or pediatrician as PCP
• Implement an approved internal & external appeals process for denied claims
• Perform nondiscrimination testing regarding highly compensated employees in insured group plans
• Provide 60 days' prior written notification if there are any material modifications

Calendar Year 2011 (FY11 & FY12)
• Report value of health coverage on employees' W-2 forms (i.e., W-2 forms issued in 2012 for 2011 wages and issued thereafter for subsequent years)
• Prohibit health account reimbursement for over-the-counter drugs (except insulin) without a prescription
• Seniors on Medicare who reach the coverage gap for prescription drugs will receive a 50% discount when buying covered brand-name drugs. Additional discounts will be received for the next 10 years until the coverage gap is closed.
• Medicare will include free preventive care services like colorectal cancer screenings and mammograms.
• Medicare high-risk beneficiaries will receive services through the Community Care Transitions Program to prevent hospital readmissions.
• Communicate to employees regarding higher penalty for withdrawal of Health Savings Account funds for non-medical expenses, *if applicable*
• Apply for wellness grants for establishment of wellness programs for small employers (<100 employees)
• Consider offering employees access to the voluntary federal long term care insurance program (CLASS Act) through payroll deduction
• Provide Uniform Summary of Benefits and coverage explanation in addition to SPD's
• Provide reasonable break time(s) for employee to express breast milk for her nursing child and provide a private "place" to do this (other than bathrooms which are not considered free from view and from intrusion from co-workers and the public)

Calendar Year 2012 (FY12 & FY13)
• Insurers and self-insured plan sponsors must issue Uniform Explanation of Coverage to employees (no later than 3/23/2012)
• Group plans and insurers must report annually to HHS and participants regarding plan benefits that improve quality of care (no later than 3/23/2012).
• Ensure that expanded Forms 1099 reporting requirements are satisfied for payments for corporate service providers in 2012 and beyond

Calendar Year 2013 (FY13 & FY14)
• Limit Flexible Spending Account contributions to $2,500 annually
• New Medicare taxes (FICA) for high wage earners (individuals making more than $200,000 per year and couples making more than $250,000 annually).
• Insurers and self-insured plan sponsors must pay a comparative effectiveness fee of $2 per participant annually, ($1 in 2013)
• Provide employees with written notice regarding availability of Exchange plans and subsidies
• Tax exclusion of Medicare Part D drug subsidy eliminated

Calendar Year 2014 (FY14 & FY15)
• Automatic enrollment of new employees; with opt-out rights, to ensure all employees have health insurance
• Plan design changes
o No waiting periods greater than 90 days
o No pre-existing conditions exclusions for any individuals regardless of age
o Cost sharing limits for group health plans
o Cover routine costs for clinical trial participants (new plans)
o No discrimination against providers with regard to plan participation (new plans)
• Communicate insurance reform changes to all employees, including individual coverage mandate, subsidies and tax penalties
• Determine applicability of free rider penalty and free choice vouchers to employer
• Determine whether to offer employees discounts of up to 30% of coverage costs for participating in a wellness program
• Report to IRS and participants regarding provision of minimum essential benefits
• Small employers (<100 employees) should determine whether to purchase coverage

through an Exchange, if applicable
• Provide disclosures to HHS and the public regarding claims procedures, enrollment information, financial information, out-of-network coverages, etc.

Calendar Year 2017 (FY17 & FY18)
Large employers (>100 employees) should determine whether to purchase coverage through an Exchange, if permitted by state

Calendar Year 2018 (FY18 & FY19)
Implement 40% tax on high cost plans (value of $10,200 for single coverage or $27,500 for family coverage)

Steps/Consideration

- ✓ Inventory all health plans and arrangements and determine which of our health plans or arrangements may qualify as "grandfathered plans" and consider how our future design changes or modifications may affect such plans
- ✓ Identify the particular plan year applicable to each health plan for purposes of complying with the Health Care Reform Law
- ✓ Confirm which changes must be made to their existing plans and when those changes must be made, based on the particular plan year and type of plan involved.
- ✓ Consider modeling the potential cost impact of the Health Care Reform Law
- ✓ Before adopting any new employee health benefit plan, merging any plans, or making any changes to existing plans, ensure that all applicable requirements are timely satisfied and consider any possible impact of such action on the grandfathered status of existing plans under the Health Care Reform Law
- ✓ Evaluate the impact of Health Care Reform Law on:
  - Plan Documents
  - Wellness programs
  - New disclosure requirements (including the new uniform summary of benefits)
  - Information contained in the SPD's
  - Enrollment materials
  - Employee notices and other communications
  - Reports to the government (including Forms W-2 and 1099)
  - Internal administrative procedures
  - Third-party administrative and business associate agreements
  - Nondiscrimination testing
  - Controlled group issues
- ✓ Update all documentation
- ✓ Determine what action needs to be taken to satisfy the new coverage summary disclosure and reporting obligations
- ✓ Consider conducting a health care compliance review to assess compliance by our health plans with existing regulatory requirements and the changes that will be necessary to ensure compliance with the Health Care Reform Law

HEALTH REFORM IMPLEMENTATION TIMELINE

In March 2010, President Obama signed comprehensive health reform into law. The following timeline provides implementation dates for key provisions in the law.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Create a state option to cover childless adults though a Medicaid state plan amendment.
- Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

2010 (continued)

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of $50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians, and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based longterm care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

2011 (continued)

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Workforce

- Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Reduce annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high–quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Prevention/Wellness

- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services.

2013 (continued)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
  - 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family in 2010);
  - 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family in 2010);
  - 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family in 2010).
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets.
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

2014 (continued)
Premium Subsidies
• Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.
Medicare
• Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019). • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. • Require Medicare Advantage plans to have medical loss ratios no lower than 85%.
Medicaid
• Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provide enhanced federal matching for new eligibles. • Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments. • Increase spending caps for the territories.
Prevention/Wellness
• Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
Tax Changes
• Impose fees on the health insurance sector.
2015 and later
Insurance Reforms
• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)
Medicare
• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
Tax Changes
• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

For additional information, see http://www.kff.org/healthreform/8060.cfm.

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274